UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

NON-SEDATING ANTIHISTAMINES

(Xyzal, Allegra, Clarinex)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES TO 855-828-4992

CRITERIA:

- **DOCUMENTATION** stating when and how OTC cetirizine, fexofenadine and loratadine preparations have failed.

INFORMATION:

Non-sedating antihistamines limited to 30 doses/30 days.

NOTE: This prior authorization is for prescription Non-Sedating Antihistamines. Over-the-counter Antihistamines are available without a prior authorization for Traditional and Non-Traditional clients.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity

4/8/13

http://health.utah.gov/medicaid/pharmacy